



North Carolina
Department of Health and Human Services
Division of Medical Assistance
Director's Office

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James B. Hunt, Jr., Governor
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Paul R. Perruzzi, Director

May 3, 2000

Tim Westmorland, Director
Health Care Financing Administration
Center for Medicaid and State Operations
7500 Security Blvd.
Baltimore, MD 21244-1850

Dear Mr. Westmorland:

I am pleased to provide the Health Care Financing Administration an original and ten copies of North Carolina's request for a Research and Demonstration Waiver under Section 1115 of the Social Security Act.

The purpose of this waiver request is to allow the State of North Carolina to extend Medicaid eligibility for family planning services to women and men of childbearing age with incomes at or below 185% of the federal poverty level who would not otherwise qualify for Medicaid. Women and men who are served through this program will be able to access all family planning services offered through the North Carolina Division of Medical Assistance through any qualified provider.

The waiver is a collaborative effort between several divisions of the North Carolina Department of Health and Human Resources - Division of Medical Assistance, Division of Public Health and State Center for Health Statistics - as well as with the University of North Carolina at Chapel Hill, School of Public Health.

In 1998, over 40% of births in North Carolina were to mothers covered by the Medicaid program. Data from the North Carolina Pregnancy **Risk** Assessment Monitoring System (PRAMS) indicates that as many as **44%** of women indicated that their pregnancy was unintended (either mistimed or unwanted). We anticipate that this waiver will have the effect of reducing the state's unintended pregnancy rate and thus impact on the health of children and families in North Carolina.

The State looks forward to the availability of these much needed services that will be made available through this waiver. Clarence Ervin, (919) 857-4045 is a contact for this project.

Sincerely,

15/
Paul R. Perruzzi
Director

Eugene Grasser

**NORTH CAROLINA
FAMILY PLANNING WAIVER
PROGRAM PROPOSAL**

1115(a) DEMONSTRATION WAIVER APPLICATION

**A PROPOSAL TO REDUCE UNINTENDED PREGNANCIES
AND IMPROVE THE WELL BEING OF CHILDREN AND
FAMILIES IN NORTH CAROLINA**

APRIL 2000

**NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
RALEIGH, NC**

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Proposed Expansion of Medicaid Benefits for Family Planning Services
In North Carolina

INTRODUCTION

The State of North Carolina is requesting a 1115(a) demonstration waiver to extend eligibility for family planning services to all women over age 18 of reproductive age with incomes at or below 185% of the federal poverty level regardless of receipt of previous Medicaid reimbursed service (pregnancy-related or otherwise). Current Medicaid regulation provides coverage to pregnant women and infants (less than 1 year) at or below 185% of the federal poverty level. These women are only eligible for Medicaid benefits following the confirmation of pregnancy and through a period of 60 days postpartum. After 60 days, women who no longer meet the state's more stringent financial criteria for participation in the Medicaid program lose eligibility for all benefits, including family planning. It has been estimated that more than two thirds of the women eligible for Medicaid in 1997 due to pregnancy (26,493) lost their Medicaid coverage after 60 days postpartum, leaving them without family planning or preventive health services coverage (NC State Center for Health Statistics) .

Additionally, we are requesting that this waiver provide family planning services for any man over age 18 of reproductive age whose income is at or below 185% of the federal poverty level.

Although the failure to delay conception for an adequate interval following the completion of a pregnancy is widely recognized as an important risk to subsequent pregnancies, there are estimates that over 290,000 women aged 20-44 in North Carolina are in need of publicly supported contraceptive services* (The Alan Guttmacher Institute data, 1998) and do not have Medicaid coverage for these reproductive health services. Although the 156 publicly supported family planning clinics in North Carolina serve 171,010 women this represents only 38% of all women in need. Publicly supported contraceptive services in North Carolina avert 39,000 pregnancies each year (AGI, 1998).

Moreover, improving the spacing of births among this population will result in reductions in the overall number of births that will be supported by Medicaid funding. The provision of this benefit might also be expected to reduce the number of low birth weight and premature deliveries, and infant deaths attributable to closely spaced pregnancies among those whose poverty limits their access to health services. This in turn impacts the costs that are incurred for

* *Women in need of publicly supported contraceptive services* are women aged 20-44 who are in need of contraceptive services and supplies and whose income is below 250% of the federal poverty level. Publicly supported contraceptive services can be obtained either from publicly supported family planning clinics or from private physicians who serve women on Medicaid.
Women in need of contraceptive services and supplies are women aged 20-44 who are 1) sexually active, that is, they have ever had sexual intercourse; 2) fecund, meaning that neither they nor their partners have been contraceptively sterilized and they do not believe that they are infecund for any other reason; and 3) during at least part of the year, neither intentionally pregnant nor trying to become pregnant.

the lifetime care of infants who are born with a disability due to their premature and/or very low birthweight status.

The coverage proposed under this waiver would involve reproductive health services currently available to other Medicaid clients in North Carolina.

GOAL

To reduce unintended pregnancies and improve the well being of children and families in North Carolina.

OBJECTIVES

- I. Increase the number of reproductive age women and men receiving either Title XIX or Title X funded family planning services by improving access to and use of Medicaid family planning services.
- II. Reduce the number of inadequately spaced pregnancies by women in the target group thus improving birth outcomes and health of these women.
- III. Reduce the number of unintended and unwanted pregnancies among women eligible for Medicaid.
- IV. Impact positively the utilization of and “continuation rates” for contraceptive use among the target population.
- V. Increase the use of more effective methods of contraception (such as Depo-Provera, Norplant, and sterilization) in the target population.
- VI. Decrease the number of Medicaid paid deliveries, which will reduce annual expenditures for prenatal, delivery, newborn and infant care.
- VII. Estimate the overall savings in Medicaid spending attributable to providing family planning services to women and men through this demonstration project.

BACKGROUND

In an average week in North Carolina:

- 2,009 babies are born
- 294 babies are born to teen mothers (ages 15-19) -
- 67 babies are born to mothers who receive late or no prenatal care
- 175 babies are born low birthweight
- 36 babies are born very low birthweight
- 18 babies die before their first birthday"

*(March of Dimes Perinatal Profiles, 1999).

Unintended pregnancy is a major problem in the United States that cuts across racial, ethnic, socioeconomic and demographic lines. By helping women to time and space their pregnancies, contraceptive use helps avoid the adverse health, social and economic consequences associated with unintended pregnancies.

It has been estimated that every year over half of all pregnancies among American women are unintended (mistimed or unwanted). According to an Institute of Medicine report, *The Best Intentions*, just over half of the unintended pregnancies ended in abortion and just under half in live births. In North Carolina, as many as 44% of women indicated that their pregnancy **was** unintended (NC PRAMS, 1998). That is, when asked, they reported that they wanted to be pregnant later (mistimed) or not then or any time in the future (unwanted). In 1998, the pregnancy rate in North Carolina for women ages 15-44 was 84.7 reported pregnancies per 1,000 women of that age group. In North Carolina in 1996, there were a total of 33,554 legal abortions. The abortion ratio was 321 (vs. 314 in the U.S. as a whole) legal induced abortions per 1,000 live births and the abortion rate was 20 per 1,000 women aged 15-44 years (Koonin, et al., 1999).

For many women, an unintended pregnancy is difficult, because it occurs when the woman is too young to be a parent or is unmarried, too soon after her previous birth or after she has achieved her desired family size.

The lack of financial access to family planning services and related health care following pregnancy undermines a continuum of care for low-income women. In 1998, 42% (46,701)* of births in the state were to mothers covered by the Medicaid program (data provided by the NC State Center for Health Statistics). By definition these women had incomes under 185% of the federal poverty level, and thus constitute a significant part of the target population for this program. These women are of particular concern because they are only temporarily eligible for Medicaid due to their pregnancy status and the majority loses their eligibility after the postpartum period. As a consequence these women are at risk for additional closely spaced, unintended pregnancies and may fail to maintain good health practices, which could promote better birth outcomes in the future.

* This number is known to be conservative due to the current inability to capture the Medicaid paid deliveries in one of the states largest counties. Mecklenburg County, in which there are mandatory Medicaid HMOs and reimbursement is under a capitated rate **plan**.

If unintended pregnancies were reduced through increased access to and utilization of family planning services, low birth weight as a factor contributing to infant mortality would also be reduced. Of particular concern in looking at the problem of low birth weight in North Carolina is the white-black gap. Just as in the case of low birth weight, there is wide disparity between the black infant mortality rate and that of white infants, with the black rate over 50% higher. Low-income women of color are at the highest risk of unintended pregnancy. In the United States, 79% of pregnancies among black women are unintended, compared with 63% among Hispanic women and 54% among white women (Forrest & Frost, 1996).

Unintended pregnancies have ramifications for individual and public health. Women who experience such pregnancies are less likely to obtain timely prenatal care than those whose pregnancies are planned; as a result, their chances of adverse health outcomes increase. Health risks are also heightened when pregnancies follow shortly after another birth or occur among young adolescents or women past their childbearing prime. A study in North Carolina found that women who had used family planning services in the two years before conception were significantly more likely than those who had not used such services to have a birth-to-conception interval of greater than six months. They were also more likely to receive early and adequate prenatal care and to be involved in a food supplement program and maternity care coordination. In addition, family planning participants were less likely than the nonparticipants to be younger than 18 and were somewhat less likely to deliver a low-birth-weight baby (Jamieson & Buescher, 1992).

An unintended pregnancy may threaten a woman’s ability to complete her education and participate in the workforce, jeopardizing her ability to support herself and her family. For this and other reasons, approximately half of women experiencing an unintended pregnancy seek abortion.

Generally in our society, the burden of contraceptive responsibility is on the woman. Male responsibility has continued to decline significantly over the years. Few pregnancy prevention programs target men. Very little research has been done concerning the impact of male sterilization on the prevention of unintended pregnancy nor on the development of male contraceptive devices. According to research by James Trussel, et al., a vasectomy is one of the most effective and economical contraceptive methods. (Trussel, et al., 1995). However, a majority of vasectomy recipients are well educated, have incomes above 300% of the federal poverty level and are white. Low income, at risk men without viable access to vasectomies are dependent on their partners to provide the most effective contraceptive option. These men have little choice and do not have direct control over their reproductive lives and future economic burdens.

Currently North Carolina has appropriated very limited funds toward vasectomy services for low-income men. The current vasectomy program provides a limited number of vasectomies to men whose incomes fall below 200% of the federal poverty level. Last year this program provided 338 vasectomies with all funding coming directly from the state. This did not meet the complete need for services that were presented at the participating sites across the state (Edens, 1999). Health departments across the state have waiting lists for subsidized sterilization services for low-income women and men.

In this country, contraceptive supplies and services are expensive and women (and men) must rely on fragmented systems and programs to help them cover these costs. The intention of this proposal is to put in place a system by which women and men in North Carolina can more easily access family planning services in the hopes that this will reduce the number of inadequately spaced pregnancies. This, in turn, should lead to reductions in the number of adverse pregnancy outcomes and lead to a net saving in Medicaid spending. Family planning may be the point of entry into the health care system for some low-income women.

We expect that public health should also improve with a concomitant benefit from a decrease in the rate of sexually transmitted diseases as a result of early detection and treatment during family planning visits, particularly with the inclusion of men in this proposal.

If women are fully supported in meeting their health care needs, they will be in a better position to exercise wisely their right to make choices regarding the spacing and number of their children and to increase the interval between pregnancies. Likewise, as a result of routine screening and examination, women and men will be able to maintain good health status, all of which will have tremendous value from a cost benefit standpoint as well as from the view of the individual and her/his family.

TARGET POPULATION

This project would provide Medicaid coverage for family planning services to all women and men in North Carolina who:

- (1) are over age 18 and of reproductive age;
- and
- (2) are at or below 185% of the federal poverty level.

There will be no requirement that a woman have already received a Medicaid reimbursed pregnancy-related service.

Teens (individuals *c* 19 years old) will not be covered under this waiver program. Currently, Title X programs have strong policies in place for serving teens confidentially and sensitively. Teens are assured confidentiality but counseled to talk to their parents and involve them in decision-making on reproductive health issues. They are also offered counseling on recognizing and resisting coercion in relationships, and family planning and STD prevention and treatment are closely linked in the health department settings. It is hoped that because Title X clinics will begin receiving Medicaid reimbursement for previously uninsured adult patients, their capacity to serve teens will expand.

Participation in this project will be voluntary for those in the target population. Recipients will not be required to choose a primary care physician through the current Carolina ACCESS program, nor will they be required to enroll with an HMO (in those counties currently participating in this project).

An applicant for this program must be a resident of North Carolina and a citizen of the United States or a qualified alien. One cannot be incarcerated. One cannot be eligible for Medicaid under any other current program.

SERVICE DELIVERY

Since we have strong indications that the extension of family planning services to women and men will be cost-effective and reduce the number of adverse pregnancy outcomes, we propose to extend services to all eligible women and men across the state, for no less than the five year project period.

ELIGIBILITY AND DURATION

The county offices of the North Carolina Department of Social Services will determine eligibility. We plan to use an amended version of the current application being utilized for the North Carolina Health Check (Medicaid) and Health Choice (CHIP) programs (DMA-5063). This application is short and should make the application process much simpler for both the Medicaid eligibility specialist and the potential recipient. Additionally, this application will be made available at public health departments and other provider sites thus allowing staff at these sites to assist potential eligibles in completing them and mailing them back to the appropriate county Department of Social Services. A Spanish version of the application will be available.

Like the eligibility determination under the current SOBRA program (MPW), there will be no resource limit for this program. The income standard will be 185% of the federal poverty level for the appropriate number of persons in the household. Proof of income will be required. The appropriate number of persons will include parents, spouse, and children under 21 years of age. Parental income will not be counted when determining eligibility for an individual less than 21 years of age. As with the MPW eligibility process, the same income deductions will be applied when calculating eligibility.

Currently, after a redetermination has been made on eligibility for other Medicaid programs, a notice of termination of benefits is sent out to persons scheduled to lose their Medicaid eligibility. For this waiver, we propose to automatically "roll" a recipient from MPW (Medicaid for Pregnant Women) coverage over into the family planning benefit category if she has not been determined to be eligible for a more comprehensive Medicaid coverage category and if she has not been determined to now be over 185% of the federal poverty limit. The recipient will be able to be transferred from the MPW program to the MAF (Medicaid for Families) program and into the new classification (family planning waiver services only) within the MAF aid category. The recipient will be informed of this by mail along with more detailed information on the new family planning coverage benefit. From this information the recipient will be aware that her partner may also be eligible for this benefit package as well as others in her community. The DSS eligibility specialists should be knowledgeable enough about the benefit to educate potential recipients on the benefits and on where to obtain services.

A brochure will be developed explaining the available services and will be included in all of these mailings. In addition, these informational brochures will be placed in DSS correspondence available to all Medicaid recipients. Providers will also be furnished with brochures explaining the additional benefit and asking them to discuss this effort with their patients.

Members of the target population who are currently covered under the MPW program often have case managers (e.g. Maternity Care Coordinators, Maternal Outreach Workers, Child Service Coordinators, Intensive Home Visitors, and mental health case managers). These case managers will also be requested to advise women receiving prenatal care of the risks associated with inadequate pregnancy spacing near the conclusion of their current pregnancy, to notify them of the availability of family planning services, and to make referrals or assist them in establishing a family planning appointment.

There will need to be a comprehensive outreach component to this project with the focus being on reaching women and men of the target population who would otherwise not consider themselves to be eligible for any Medicaid benefit.

It is our plan to create a new classification within the already existing MAF (Medicaid for Families) aid category to accommodate this new target population. A distinct Medicaid identification card will be issued for recipients. Members of the target population due to lose already existing Medicaid coverage, and determined to be at or below 185% of the federal poverty limit, will be moved to the new eligibility category and will automatically become eligible for extended family planning services. A new Medicaid identification card will be issued, though the Medicaid identification number for this population will remain the same.

Members of the target population will receive Medicaid coverage of family planning services for no less than the entire project period, with focus and implementation being first on postpartum women. Services will be available for the entire waiver project period. An application to cover a 3-month retroactive period will be allowed. There will be no copayment for any covered services rendered, in accordance with the NC Administrative Code (T10:26D.0116(b)(2)).

Once eligibility has been determined, a redetermination of eligibility will be required every year. Recipients will be asked to report any changes to the county caseworker and any decrease in income will elicit the county caseworker to make sure the recipient is not either eligible for another Medicaid program that may provide more extensive medical coverage for this recipient. Any increase in income will elicit the county casework to assess whether the individual is no longer eligible due to being over 185% of federal poverty limit.

A woman who decides that she does not wish the "continued" coverage (from MPW to family planning only coverage) can report this to Medicaid and be terminated. Eligibility through the demonstration project would also be terminated if the woman or man moves out of state, dies or if she/he is found to be eligible under another Medicaid category (i.e. income drops significantly, becomes disabled and qualifies for SSI). If a woman becomes pregnant, these services would no longer be indicated, although she may now become eligible for the Medicaid for Pregnant Women (MPW) program. At this time, the woman would need to undergo a redetermination to determine if she still falls within the income guidelines (up to 185% FPL).

Local county Departments of Social Service as well as the NC Division of Medical Assistance will continue to monitor the level of quality assurance in the provision of eligibility determination as is done currently with all other Medicaid eligibility categories.

Individuals eligible under the family planning waiver will have the same confidentiality protections that current Medicaid eligibles have.

SERVICES

Family Planning services are a major preventive strategy for reducing unintended pregnancies and infant deaths and for improving family health in North Carolina. They also serve as the intervention and referral site for other women’s health concerns. The proposed project expanding eligibility for these services to reproductive age women and men will:

- 1) Allow affected women the opportunity to choose if and when to have children.
- 2) Provide comprehensive reproductive health care for low-income women and men in North Carolina who otherwise do not have access to such services.
- 3) Provide education, screening, and early detection of sexually transmitted diseases (STDs), including HIV/AIDS for women and men.
- 4) Provide the opportunity for men to take responsibility for being the primary contraceptive (i.e. making vasectomies a viable option).
- 5) Reduce the demand for abortion by many low-income women.

Women and men enrolled in the demonstration project will be eligible for all family planning services currently covered by the North Carolina Medicaid program. Family planning services are available to all Medicaid recipients and include all medical and counseling services related to alternatives for birth control and pregnancy prevention services. The Division of Medical Assistance will utilize existing policy and reimbursement requirements for providers providing family planning benefits. Included in these services will be:

- Family planning initial or annual examinations (including appropriate physical exams)
- Family planning counseling visits
- Family planning supply visits
- All FDA approved and Medicaid covered methods of birth control (including removal of implants/inserts)
- Tubal ligations and vasectomies and necessary post-procedure follow-up (upon receipt of proper federal sterilization consent form per current Medicaid regulations)
- Laboratory tests that are in conjunction with the family planning visit
- Evaluation and management visits for STD diagnosis, treatment and follow-up

- Antibiotics for STDs
- HIV testing including pre and post test counseling visits (treatment will not be covered)
- Hepatitis B immunizations if recipient falls into Medicaid covered risk group(s)
- Pregnancy tests
- Pap smears and colposcopies (with or without biopsy) as warranted.

Abortion services will not be covered under this program. Infertility services and related procedures will not be covered. Treatment for AIDS and cancer will not be covered. Management or treatment of medical conditions/problems (not including STDs) discovered during screenings or caused by or following a family planning procedure (i.e. medical complications from family planning procedures) will not be covered (e.g. UTIs, diabetes, hypertension, breast lumps, etc.). (See Attachment I)

Like other Medicaid recipients, this coverage group will be eligible to apply at the Department of Social Services for assistance with transportation to appropriate medical appointments. This would be a key item on which to educate new and potential recipients in relation to issues of access.

The Medicaid client is assured freedom to select any Medicaid family planning provider from the following provider types: physicians, physician assistants, nurse practitioners, county health departments, rural health clinics, federally qualified health centers, birth centers, and family planning projects or agencies who are enrolled in Medicaid. There are no expected changes in current provider eligibility policies.

Upon enrollment and certification as a Medicaid provider, the provider may bill for Medicaid family planning services within their scope of practice. Providers receive family planning service information primarily through monthly provider bulletins and updates to their manuals. New providers will receive information regarding the extended family planning services in their Medicaid enrollment package.

The family planning services contemplated in this project will be provided in accordance with accepted standards of care. Additionally, all recipients receiving Medicaid funded family planning services will be tracked to monitor service utilization and access to care.

These services would complement the existing Title X Family Planning Program currently administered by the North Carolina Department of Health and Human Services, Division of Public Health, Women's and Children's Health Section. This program provides family planning services according to published Federal guidelines. However, only approximately 25% of family planning funding comes from Title X and these funds have never been able to meet the need for services that exist (Edens, 1999). Dollars have no longer been available to support either the clinic infrastructure or the overall population in need of subsidized family planning services across the state; rather, the dollars have been limited to the much smaller population of welfare recipients (Gold & Sonfield, 1999).

Currently, local public health agencies have written policies in place for their provision of family planning services that include:

- a) Description of local family planning services, including local protocols, standing orders and components of Initial, Complete, Limited and Extended Revisits, as well as procedures for sterilization services.
- b) Tracking mechanisms for follow-up of abnormal clinical and laboratory findings.
- c) Follow-up of family planning patients with positive pregnancy tests to assure patient has access to health care provider.
- d) Protocol for clients wanting permanent contraception.
- e) A written plan/protocol that addresses education, counseling, and referral regarding: HIV/AIDS, Hepatitis B infection and immunization.
- f) Counseling family planning postpartum clients to delay pregnancy for at least 12 months after delivery.
- g) Provision of emergency contraception on-site or by referral.

Persons enrolled in these agencies' family planning programs are provided the following services as documented in their medical charts:

- a) All patients will receive an initial or updated history which includes: medical, social, family, surgical, menstrual, genetics, contraception, tobacco/alcohol/drugs, medication, obstetrical and immunization (Td, Rubella) on initial or complete visits.
- b) All patients will receive a physical examination on initial or complete visits which includes: weight, height (if growth not complete), blood pressure, breasts, heart, lungs, abdomen, extremities, complete pelvic examination and, if indicated, a rectal examination.
- c) Limited visits will include reason for visit, method specific history, weight, blood pressure and education and counseling if indicated.

The following tests are obtained on all initial or complete visits and documented in the medical record unless a normal result has been obtained in the last six months:

- a) Hematocrit or hemoglobin.
- b) Urinalysis for sugar and protein if indicated.
- c) Papsmear.
- d) Gonorrhea culture.
- e) Syphilis Serology-required on initial visits, required on complete visits in the presence of a positive gonorrhea culture or on other visits as indicated by the clinician-may omit on clients having a documented negative VDRL from any source within the past six months unless there is a history that indicated that the client is at high risk for exposure to syphilis. Note: HIV testing is recommended in the presence of a positive syphilis serology.

Assessment for Rubella and Tetanus-diphtheria immunity will be documented in the patient's record on all initial and complete visits:

a) At their initial visit, clients able to provide written documentation of rubella immunity will have this status documented on their charts. Once immunity is documented, no further assessments are needed. Clients unable to provide this documentation will receive either:

- a rubella titer and vaccination if susceptible, or, -
- a rubella vaccination.

b) Tetanus-diphtheria assessment includes documentation of Tetanus-diphtheria vaccine within the last ten years. If no documentation, Td vaccines should be given.

Education and counseling will include the following:

- a) Client will receive information on all FDA-approved contraceptive methods and their risks and benefits (including natural family planning, and for teens, abstinence).
- b) Client will receive additional information specific to the contraceptive method(s) to be used.
- c) Education in **HIV** infection and AIDS including counseling on risk assessment, **HIV** prevention and how to get tested (on-site or referral) will be provided.
- d) All minors will be: (1) offered counseling on how to resist coercive attempts to engage in sexual activities; (2) provided this counseling in cases where the minor requests it; and, (3) provided counseling and other appropriate services where there is physical evidence or evidence by history that such counseling is indicated.
- e) Required education offered outside the family planning clinic will be assessed, documented, and updated as appropriate according to the needs of the individual family planning patient.

A method specific consent form will be reviewed with client, dated, signed by client, and copy given to client.

- a) A new consent form will be signed when there is any change from one method to a different method. (Not required when changing oral contraceptive prescriptions).
- b) Risks specific to the individual due to her/his use of the chosen contraceptive method will be identified.
- c) Minors under 18 years of age may sign the consent form but will be counseled about the importance of discussing birth control needs with parent(s).
- d) Information about emergency and after-hours services will be provided.

Screening, Diagnosis, Treatment and Follow-Up Services

There will be evidence in the record that:

- a) Significant problems were identified and documented.
- b) Significant abnormal clinical and laboratory findings were discussed with the client.
- c) Problems, conditions, and abnormal findings are appropriately followed.

We expect that this same level of service will continue. Additionally, with some of the population currently receiving services through local health departments expected to become eligible for Medicaid reimbursed services, we would hope that Title X program funds previously used on now Medicaid-eligible clients would be available to serve additional numbers of non-Medicaid eligible clients and teens.

We would expect the proposed project to serve some women and men who are not currently receiving family planning services, in some cases because they are not well informed about the risks of poorly spaced pregnancies, and in some cases because their financial condition limits their access to health services.

COSTS

The lack of access to family planning services has costly repercussions. In 1996, the average cost to Medicaid per very low birth weight baby (less than 1500 grams) was \$56,576 for the first year of life, with \$49,494 of that cost occurring within the first 60 days of the infant's life. In 1997, the average cost to Medicaid per very low birth weight baby (less than 1500 grams) was \$56,068 for the first year of life, with \$50,600 of that cost occurring within the first 60 days of life (from a report prepared by the NC State Center for Health Statistics). One must also consider the costs incurred for the lifetime medical care of a child born with a disability. As an example, the lifelong cost of supporting one child with severe mental retardation can be up to \$2 million.

The average cost of all prenatal care, delivery, neonatal and infant care in North Carolina was approximately \$8000 per pregnancy in 1997. In contrast, the average cost of reproductive health services is approximately \$280 (\$160 for care provided within a health department and \$320 for care provided outside of the health department) per year per recipient (Medicaid costs for SFY 1999 – all family planning related services – pharmacy, outpatient, inpatient).

It is estimated that a year of family planning services will prevent one unintended pregnancy per year for every fifteen recipients. Additionally it has been reported that for every dollar spent to provide publicly funded contraceptive services, an average of \$3.00 was saved in Medicaid costs for pregnancy-related health care and medical care for newborns (Forrest & Samara, 1996). Thus, looking at the costs above, it is obvious that implementation of this proposal would be extremely cost effective to the state Medicaid program as well as to other programs in the state that work with women, children and families.

Additional non-Medicaid federal savings are expected to accrue but have not been estimated. These would include costs for programs such as WIC, food stamps, TANF, government subsidized childcare, care coordination services, etc. Savings in terms of decreased social costs are incalculable.

EVALUATION

The evaluation plan' for this waiver proposal will be a multi-layered proposal. It will consist of both quantitative and qualitative analyses designed to address the objectives of the waiver program. It will evaluate both the process and the outcomes of this new program and include

* DMA would like to thank Dr. Neva Edens, MD, UNC Family Practice Center, Chapel Hill, NC and MPH candidate, UNC School of Public Health, Chapel Hill, NC for her extensive work on the evaluation plan.

trend analysis and secondary analysts of existing data sets as well as original research designed to address any questions left unanswered.

The evaluation will be a collaborative project between program staff at the Divisions of Public Health and Medical Assistance and statisticians at the State Center for Health Statistics (SCHS) and researchers at the School of Public Health at the University of North Carolina at Chapel Hill. The collaborative design will allow for maximum resource allocation and teamwork between program staff, researchers and statisticians.

Trend Analysis

Although client data, vital statistics, and population survey data are readily available for use in the program evaluation, conclusions made by these data alone would be limited to trend analysis only. Client data from the Division of Medical Assistance (DMA) would provide the number of clients as well as the cost per client served at baseline and through all five years of the program. Vital statistics from the SCHS would provide tracking of the number of births that occurred to women enrolled in the program from year to year and their birth outcomes. All of these data are important to document and might provide some information to suggest that the program had an impact on the eligible population. Unfortunately since none of these data described above provide concurrent control groups, specific conclusions about the direct impact of the program are difficult to make using trend analyses alone. Secular effects or other programmatic changes from year to year would also affect the measured outcomes. Trend analysis provides no direct evidence that would allow program officials or policy makers to attribute any specific changes in pregnancy rates, for instance, directly to the waiver program.

Population survey data would provide cross-sectional measures of the various personal health behaviors (contraceptive use, health care access, and unintended pregnancy rates) that could be affected by the waiver program. These surveys may provide more detail about the attitudes and behaviors of the eligible population, but because they simply survey a representative sample from a large group at only one point in time, they serve only as another form of trend analysis. They provide no longitudinal assessment of the changes in behavior for particular people within the eligible population from year to year. Identifying specific individuals and following them over time through a cohort design (either historically or concurrently) would provide more evidence about the relationship between the intervention (the Family Planning Waiver program) and the outcomes of concern (unintended pregnancy, contraceptive use, etc).

Trend analysis using the data described above is the least costly option for an evaluation study design. The costs would include only the costs attributable to organizing the evaluation team, collecting all the data from various sources and processing it into an annual report. Data would need to be collected at baseline and each of the 5 years the family planning waiver program is in effect and one following (since births averted in year 5 will have effects into year 6).

Two Retrospective Cohort Studies

A retrospective analysis of the Family Planning Waiver program users would be possible using available population surveys if questions were added to the surveys allowing respondents to identify whether they received Family Planning Waiver program services or not. These additional questions provide an independent variable that can be used in the analysis of the dependent variables (the outcomes of interest). If all the low-income respondents in a population survey could be identified as waiver services users or non-waiver services users, then comparisons can be made between these two groups. Possible outcome measures include the rates of unintended pregnancy among those low-income respondents who received Family Planning Waiver program services and those that did not. A multivariate statistical analysis controlling for other variables measured in the survey that are risk factors for unintended pregnancy would be used to identify an odds ratio for having an unintended pregnancy if one obtained Family Planning Waiver program services after controlling for other factors. Like trend analysis this study design, because it uses cross-sectional data, does not provide strong evidence for cause and effect. Any findings would be limited to associations only.

A retrospective cohort study using Medicaid claims linked with vital statistics (birth certificate data available through the SCHS) is another way to compare Family Planning Waiver program users and non-users. Since DMA plans to identify Family Planning Waiver program recipients by providing a special Medicaid card and a specific designation within the data system, identifying men and women who received waiver services could easily be done through MMIS data. This study design involves using available birth certificate data linked to Medicaid claims to retrospectively identify all Medicaid births that occurred in a particular time frame (the 1 to 3 year and 1 to 6 year period after implementation of the Family Planning Waiver program). Within the group of women who had Medicaid deliveries, Medicaid claim information could identify those who received waiver services in the years prior to their delivery. The group with Family Planning Waiver program claims could be compared to the group without. Outcome measures including birth outcomes (fetal deaths, low birthweight) and pregnancy spacing (measured by average length between pregnancies and percentages of second pregnancies with a short birth interval) could be measured and compared between the Family Planning Waiver program users and non-users. A multivariate analysis controlling for other risk factors for low birthweight (age, race, income, medical risk factors, smoking, and alcohol - also available from birth certificate data) would be used. For the outcome of pregnancy interval, a similar multivariate analysis could be done controlling for other factors including preterm delivery (which could effect pregnancy interval substantially). After controlling for confounders, the risk of low birthweight, fetal death, and short inter-pregnancy interval could be compared (through the use of an odds ratio) between low-income women who receive Family Planning Waiver program services and those who did not.

There are many advantages to the retrospective design described above. The data are readily available through the SCHS and provide information about confounders. Since Medicaid claims data from one individual can be analyzed over time, this study provides more evidence for a potential cause and effect between the intervention (Family Planning Waiver program) and the outcomes measured.

There are many disadvantages to this retrospective design as well. Only women who had children are included in this data therefore the findings are limited to only a subset of the eligible population. The perfect control group for this study would be a group who obtained no family planning services anywhere with any type of program in the years prior to pregnancy but this information is not available. Although Medicaid claims can identify a group of women who did not receive Family Planning Waiver program services or standard Medicaid services before pregnancy, these claims provide no information about whether those women received services elsewhere. This particular study may be comparing a group of women who got Family Planning Waiver program services to a group of women who received no care at all, accessed care in private settings and paid out of pocket, got care through private insurance or received Title X funding.

Despite the significant limitations of both retrospective analyses, these study designs provide the best information for comparing significant outcome measures between Family Planning Waiver program and non-Family Planning Waiver program users without significant expense or complexity. If both studies were carried out they would provide information about pregnancy spacing and unintended pregnancy rates, two important health outcome measures for the evaluation of the Family Planning Waiver program. The combination of the two studies allows for inclusion of women who were pregnant and some that were not.

Prospective Cohort Study

A more extensive original research design that involves establishing a cohort of people who are eligible and following them over the waiver period is being considered. Due to the extreme complexities and costs of this type of design, the research group at the UNC-CH School of Public Health will consider pursuing outside funding sources to fund this project.

Data for the evaluation will come from multiple data sets including client data, vital statistics, and population surveys. Much of this data is already readily available through either the Division of Medical Assistance (DMA) or the State Center for Health Statistics (SCHS). The details of the available data sources are discussed below.

Client Data

The current Medicaid collection system, called MMIS, includes a record of services provided by diagnosis code and can be used to calculate average costs for services. With the recent addition of the DRIVE system (a custom-developed Window-based program that accesses DMA's data warehouse), year to year comparisons of the number of clients served through the Family Planning Waiver program and the number of procedures paid for by the waiver program (including preventive services and sterilizations) can be accessed easily. By identifying clients with claims for other Medicaid services (including pregnancy), the DRIVE system would allow for retrospective comparison of rates of Family Planning Waiver program services obtained by all pregnant women who received Medicaid. Potentially, the claims data could be used to analyze the frequency of continuity visits for clients who received services through the Family Planning Waiver program, who had visits for routine pregnancy care or pregnancy complications. These data will be available through DMA.

The Department of Health and Human Services, Division of Public Health, Office of Women's Preventive Health tracks clients using family planning services at public health clinics in North Carolina. The Office could provide a breakdown of the percentages of clients in public settings who receive Medicaid for family planning and provide information about the clients who continue to receive Title X or other funding for family planning services after the Medicaid program is implemented. It is likely that the Medicaid waiver program will provide a new source of funding to many clients who previously received Title X funding. This new Medicaid funding is available to any Medicaid provider either in public or private settings; therefore, the Family Planning Waiver program could allow more women to seek private family planning services. Monitoring the number of clients served within the public health settings both before and after the Family Planning Waiver program is implemented would be important, as would tracking the percentage of women in public settings who are receiving Medicaid (Waiver program) vs. Title X funding. These data would be readily available through the Department of Health and Human Services.

Vital Statistics Data

North Carolina's State Center for Health Statistics (SCHS) maintains a database of Medicaid claims linked with birth certificates. This provides information about birth spacing and birth outcomes for women whose delivery was paid by Medicaid. Since the population who qualify for Medicaid when pregnant (at or below 185% of FPL) is the same as the eligible population for the Family Planning Waiver program, this can be used to monitor birth outcomes and birth spacing for the Family Planning Waiver program eligible population. By linking this data to DMA claims, secondary analysis of birth outcomes (low birthweight, fetal deaths, pregnancy complications and spacing as listed on the birth certificate) could be compared retrospectively between the women with Medicaid births who received waiver services and those who did not. These data are readily available through the North Carolina Center for Health Statistics.

Population Survey Data

Pregnancy Risk Assessment Monitoring System

The Pregnancy Risk Assessment Monitoring System (PRAMS) was developed in 1987 and is a part of the Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. It is an ongoing, population-based surveillance system that was designed to identify and monitor selected self-reported maternal behaviors and experiences that occur before, during and after pregnancy among women who deliver live-born infants. Eighteen states and the District of Columbia, representing 35% of all U.S. births, are now participating in PRAMS surveillance surveys.

North Carolina began using the PRAMS survey in July of 1997. To obtain adequate information about poor birth outcomes, the sample of mothers surveyed in North Carolina is weighted to contain a larger portion of low birthweight babies. Every month, a stratified systematic sample of 200 new mothers is selected from a frame of eligible birth certificates. Each mother receives the 14-page questionnaire at two to six months after delivery. Second and sometimes third surveys are sent to those who do not respond and the PRAMS staff phone those mothers who do

not respond at all to the survey. From July to December 1997 overall response rate was 73 percent.

The health indicators addressed by the PRAMS survey cover a variety of topics, most of which are also designated *Healthy People 2000* objectives. Questions address prenatal care, Medicaid coverage, participation in the Special Supplemental Nutrition Program for Women, Infants and Children (WIC), breast-feeding, smoking, drinking, stressors, hospital stays for delivery, and infant health. All of these measures will provide useful data in evaluation of a new family planning program in the state of North Carolina. The PRAMS measure for intendedness of pregnancy will be most valuable in evaluating the Family Planning Waiver program objective of decreasing unintended pregnancies in this state. Data from 1997, 1998 and 1999 PRAMS surveys will serve as baseline measures for the rates of unintended pregnancy in this state. According to an analysis of the July through December 1997 PRAMS data (representing 852 women with live births who responded to the survey), 45 % of these women report that their pregnancies were unintended. Thirty-four percent said they did not want to be pregnant at that particular time (but might in the future) and 11% said they did not want to be pregnant then or at any time in the future. These data for the state are maintained by and available through the North Carolina Center for Health Statistics.

The PRAMS survey would identify a proportion of the women who were eligible for Family Planning Waiver program services by their use of Medicaid during pregnancy. Since almost half of the current births in North Carolina are Medicaid births, a large proportion of the women sampled by PRAMS received Medicaid during their pregnancy. There is a question on the survey that allows respondents to identify Medicaid as their source of payment for delivery. The eligibility criteria for Medicaid during pregnancy is 185% of the federal poverty level, thus almost all of the women who identify Medicaid as their payment source for pregnancy services would have also been eligible for Family Planning Waiver program services. There are exceptions however, since a woman who is pregnant is counted as two people in the family size calculation. Cases would exist where someone could qualify for Medicaid during pregnancy by income eligibility but not qualify for the waiver program even though the income criteria is 185% of the federal poverty level for both programs. Therefore, the group of women who identify themselves as receiving Medicaid during pregnancy is not exactly the same as those who would be eligible for the Family Planning Waiver program.

In addition to not identifying the exact population of pregnant women who would qualify for the Family Planning Waiver program, PRAMS, since it is a postpartum survey by design, would not identify any woman eligible for the waiver program who did not become pregnant or chose to terminate a pregnancy. Even with these limitations, the PRAMS survey would be a useful way to obtain information about a proportion of the Family Planning Waiver program eligible population. The PRAMS data are available for this evaluation through the SCHS.

Behavioral Risk Factor Surveillance System

By the 1980s the relationship between personal health behaviors and chronic disease morbidity and mortality became clearer. In 1984 the CDC established the Behavioral Risk Factor Surveillance System (BRFSS) to collect state-level data on the prevalence of such behaviors in

adults 18 years of age and over to help inform the planning and evaluation stages of health promotion and disease prevention programs in the states. The BRFSS is a telephone survey that consists of a standard core questionnaire for all states to use as well as additional modules addressing specific health issues that states can add to the core questionnaire. The standard set of questions allows for comparison from state to state. If states have issues that are not addressed either by the core questionnaire or the available supplementary modules, states can add their own additional questions to determine the prevalence of specific health concerns or to assess an on-going state program or intervention.

The BRFSS core questionnaire addresses a wide variety of health behaviors including smoking, alcohol, nutrition, activity level, cardiovascular risks, preventive health screening and health care access. It does not address issues of family planning, contraception or pregnancy. A separate Family Planning Module does exist to address these issues asking specifically about pregnancy history, pregnancy intendedness during last pregnancy, current sexual activity, current contraceptive use, reason for not using contraception now, source of services for family planning, and time since last family planning visit. This Family Planning Module was added to the BRFSS survey in North Carolina in 1999 and results from this survey will be available in May 2000. Currently, this family planning module is provided only to female respondents in the BRFSS survey.

Eligibility for BRFSS, unlike the PRAMS written survey, is determined by random digit dialing of telephones through the use of computer technology. Since administered only by telephone, it misses the 7% of North Carolina residents without phones. The population without phones is more likely to be lower income and more likely to fall into the Family Planning Waiver program eligible group. To correct for this problem, post-stratification weights are used which may partially correct for any bias caused by non-telephone coverage. These weights adjust for differences in probability of selection and non-response and must be used for deriving representative population-based estimates of risk behavior prevalences. In North Carolina the median response rate of all the people who were contacted and found eligible was similar to the national rate of 73.4 %.

Unlike the PRAMS survey, the BRFSS survey (with the additional Family Planning Module) provides information from women who have never been pregnant or have not been pregnant recently. PRAMS only surveys recently pregnant women and thus those who chose to continue their pregnancies to delivery. BRFSS could provide the missing data from the women who are eligible for the Family Planning Waiver program but have never been pregnant, have not had a recent pregnancy or recently chose to have terminations.

Like PRAMS, the BRFSS would not identify the exact group eligible for the Family Planning Waiver program. Even with the addition of the Family Planning module there is currently no question that **asks** the respondent their payment source for these services. Family Planning Waiver program eligibility is determined by income (185% FPL), but BRFSS asks only broad questions of income to establish demographic information. BRFSS provides little information to assess a respondent's income by percentage of poverty. Identification of the group most likely to be eligible for the waiver program would involve an analysis of the lower two or three income groups (out of the five possible responses). The two lower income groups would include anyone

with household incomes at \$25,000 per year or less while including the 3 lower income groups would allow incomes up to \$35,000. Family Planning Waiver program eligibility is determined by a combination of size of household and income, therefore some of the respondents in the third group might be eligible if their household size was 3 or above. There were 777 people in the two lower income groups in the 1998 BRFSS survey in NC and the next income group contained 413 more people for a total of 1290 respondents. Including all 3 groups would give a larger sample but increase the chance of containing respondents who are not eligible for the Family Planning Waiver program. Perhaps trend analysis could be done with all income groups for comparison.

Despite its limitations, the BRFSS would provide useful information about a proportion of the Family Planning Waiver program eligible population in North Carolina that was not identified through the use of the PRAMS survey data. The state BRFSS survey, like the PRAMS data, is readily available through the North Carolina Center for Health Statistics.

Additional Data Needed

For trend analysis alone the data available through DMA, SCHS and the CDC would be sufficient, however for any further secondary data analyses additional data is needed. In order to compare Family Planning Waiver program users to non-users in a retrospective cohort design using the population survey data described above, researchers must be able to identify those respondents who are waiver program users. At this point neither the BRFSS or PRAMS surveys contain a question that allows for identification of the source of payment for family planning services. An additional question should be added to the PRAMS survey as well as the BWS family planning module to allow the respondent to identify if he or she received Family Planning Waiver program services or not. The question added could be as simple as "Did you receive family planning services through the Family Planning Waiver program (or some other term that uniquely identifies this Medicaid expansion program)?", but the question may need to involve more explanation as many respondents who were waiver recipients may not recognize the program unless it is described in several different ways.

A "male version" of the BRFSS family planning module should be produced to provide information about men's perceptions of pregnancy intendedness, contraceptive use and use of family planning services. A male version is in use in Oregon where a similar Family Planning Waiver program has been implemented and this could easily be adapted for use in North Carolina. Both PRAMS and BRFSS for NC are maintained at SCHS and the Center is agreeable to the addition of these questions to the surveys provided some payment is made (\$600 per question added).

Process Evaluation

The Family Planning waiver program is designed to achieve the goals described by the objectives listed on page 2: lower unintended pregnancy rates, increasing contraceptive use, decreasing costs, etc. However these objective outcomes should not be the entire focus of the evaluation of this program.

If the outcome evaluation results suggest this program impacted rates of unintended pregnancy or contraceptive use, it would be important to know how and why that happened. If the evaluation shows mixed effects or even no effect on the outcomes measured, it would be even more important to understand what factors may have contributed to this lack of effect. For other states considering family planning eligibility expansions or even for states who have an option to discontinue or adapt their own programs, a more thorough evaluation of the process of North Carolina's Family Planning Waiver program could provide important recommendations for change.

The research group proposes to utilize a model called the RE-AIM model (Glasgow & Vogt, 1999) for the process evaluation of North Carolina's Family Planning Waiver program. This RE-AIM model recommends that public health evaluations assess the Reach (proportion of the target population that participated in the intervention) - this might include obtaining demographic information on participants and non-participants in the program as well as their own explanations for becoming involved in the program or for not participating; *Efficacy* (success rate if implemented as in guidelines; defined as positive outcomes minus negative outcomes) - this might include an assessment of the impact on the clinic settings as well as other funding sources for family planning services and behaviors and opinions of recipients and providers; Adoption (proportion of settings, practices, and plans that will adopt this intervention) - this might include looking at numbers of claims coming through from the public vs. private sector and surveys directed at provider sites; Implementation (extent to which the intervention is implemented as intended in the real world) - this might include measures (surveys, site visits) of how clinics organize the enrollment of these recipients and specific barriers faced; and Maintenance (extent to which a program is sustained over time) of an intervention - this might include an analysis of well this new program has become an enduring part of the behavior of the clinic site or community at large. These dimensions occur at individual, clinic and community levels and interact to determine the public health and population-based impact of an intervention. The RE-AIM model provides a useful framework for the development of a process evaluation for the Family Planning Waiver program.

The process evaluation plan proposes to utilize a combination of surveys, focus groups and in-depth interviews to assess the reach, efficacy, adoption, implementation and maintenance of the waiver program. Again, Oregon's plan for focus groups and in-depth interviewing of participants could serve as a useful guide for North Carolina's Family Planning Waiver program. To supplement the focus groups and address issues of implementation and maintenance, Oregon has planned to use in-depth interviews with providers of family planning services to assess the utilization of the program and program barriers from the perspective of the providers.

One way to use the focus groups to North Carolina's full advantage might be to target this population for marketing. The focus group for the survey, after completing all their study requirements, would be the ideal group to target marketing interventions of the Family Planning Waiver program. Identifying a group of people who did not receive Family Planning Waiver program services for a combination evaluation and marketing intervention might be a cost-effective plan for North Carolina.

OUTREACH

Currently, North Carolina has a very successful toll-free telephone hotline called the North Carolina Family Health Resource Line (1-800-367-2229 or 1-800-976-1922 TTY M-F 9 am to 7 pm) which is able to provide (in English and Spanish) extensive education and referral related to a multitude of women's, children's and family services across the state. This hotline is already marketed across the state. Information about the new family planning Medicaid coverage program will be incorporated fully into the hotline's database and knowledge base.

Additionally, working through the NC Division of Public Health, there is currently a very successful marketing and outreach campaign underway related to the new CHIP program in NC (NC Health Choice). Utilizing many of the same resources and techniques, this new Medicaid eligibility category and coverage of new populations and services will be marketed throughout the state.

Providers and potential recipients will receive information about the services covered, the target population and eligibility requirements. We are well aware that the task of educating potential recipients and providers of vasectomy services will be crucial to the success of this waiver program. Health clinics that offer services through the state vasectomy program will have a key role in education and referral of potential clients.

Medicaid eligibility staff, as well as others, at county Departments of Social Service as well as staff outstationed in health clinics will become knowledgeable of this program and be able to educate new and existing Medicaid recipients of these services and eligibility requirements.

Case managers and outreach workers in public health, mental health, and social service programs will be utilized as well for purposes of education, marketing and outreach of this new program. The state of North Carolina has a number of initiatives underway that have direct access to and impact on large segments of the potentially eligible population (e.g. Baby Love Program, Intensive Home Visiting Projects, Healthy Start Baby Love Plus Projects, Minority Infant Mortality Reduction Projects, Smart Start initiatives, Adolescent Pregnancy Prevention Programs, Adolescent Parenting Programs, etc.). The state has several models of outreach that can be built upon and expanded to serve the needs of this new program. This might include the addition of a staff person at each county health department for the purpose of recruitment of potential recipients as well as education of the community (including providers, worksites, etc.) and tracking of recipients receiving services.

Initial efforts will focus on working within already established programs and with already identified populations of potentially eligible clients (including recipients of Medicaid for Pregnant Women) to increase awareness of this new program and knowledge of how to access services.

There will need to be further work done after this initial phase to identify other populations in North Carolina at risk for STDs and unintended pregnancy, but who will be harder to reach and educate on the need for family planning and its availability. We do have resources in the state that we can work with to map these populations, identify needs and plan strategies for

appropriate marketing and outreach campaigns. As mentioned in the evaluation section, focus groups and surveys will also be useful in targeting marketing strategies and identifying barriers to care. We plan to utilize these resources as the need arises.

Outreach efforts are important to not just inform the potentially eligible population of the availability of Medicaid coverage for these services and the services offered, but also to make them aware of the importance of family planning and the use of contraceptives. Outreach efforts and education are also crucial for the providers of the services, particularly private providers.

The current plan is to establish a position at the Division of Public Health, Women's and Children's Health Section, Women's Health Branch, Women's Preventive Health Unit to work exclusively on the implementation of this waiver proposal. This individual along with a staff person at the Division of Medical Assistance, staff with the research/evaluation team, others within the Division of Public Health, Division of Social Services, and local provider staff will work on the models for recruitment and education of recipients and providers. An outreach, education and marketing plan will be developed. We envision that we will initially target families and women previously on Medicaid due to a pregnancy. We would need to target males and then women previously unaware of Medicaid programs. Eventually, we would need to develop strategies for the broader market to raise public awareness of expanded access to family planning services, targeting low-income populations in general. Due to the expansion of the welfare-to-work programs, it would be important to educate and perhaps recruit employers as possible service sites for education and services in the workplace.

WAIVERS

North Carolina requests federal authorization to waive the following provisions of Title XIX of the Social Security Act to implement extended family planning services:

- 3** *Amount, Duration and Scope of Services.* Section 1902(a)(10)(B) and 42 CFR, ss. 440.230-250, require that the amount, duration, and scope of services be available equally to all recipients within an eligibility category and be available equally to categorically eligible recipients and medically needy recipients. The amount, duration and scope of services for women and men receiving the family planning waiver benefit will vary from those available to recipients enrolled in traditional eligibility categories.

Section 1902(a)(10) and 42 CFR, ss. 441.10, contain minimum requirements for Medicaid benefits. A waiver of the minimum benefits is required for family planning waiver recipients, who will be ineligible for other benefits covered in traditional Medicaid eligibility categories.

- 3** *Income Limitations.* Section 1902(l), Section 1903(f), and 42 CFR, s. 431.100 ~~et seq.~~, prohibit payment under Medicaid to states which implement eligibility standards in excess of the maximum allowed by federal regulations. North Carolina requests a waiver to expand eligibility for family planning services to individuals with family incomes up to 185 percent

of the federal poverty level. Income levels for other Medicaid eligibility categories will remain as stated in the Medicaid State Plan.

- 3** *Resource Limitations.* Sections 1902(a)(10)(A)ii, (II) and 1902(a)(17) require states to take into account income or resources of individuals who are not receiving assistance under TANF who might otherwise become eligible for assistance under TANF. Women and men who receive family planning waiver services will not be subject to an asset test as part of the eligibility determination for federally financed medical assistance.
- 3** *Other Eligibility Standards and Procedures.* North Carolina requests a waiver of ss. 1902(a)(17) and 1902(a)(10) and 42 CFR, s. 435.100 and 42 CFR, ss. 435.602, to enable the state to waive income disregards and resource limits, base financial eligibility solely on gross income, waive income determining rules and base eligibility on a household family unit. North Carolina requests a waiver of Sections 1902(a)(10)(A) and 1902(a)(34) and 42 CFR, ss. 435.401, to enable the state to streamline eligibility rules for the family planning waiver services and base income eligibility solely on gross income.
- 3** *Erroneous Payments.* Section 1903(u) permits HCFA to withhold FFP for a state's erroneous excess payments for medical assistance. The Secretary may reduce FFP where erroneous payments exceed three percent of total medical assistance expenditures. North Carolina requests a waiver of s. 1903(f) and implementing regulations at 42 CFR 435.100 *et seq.*, which restrict Medicaid payments to eligibles whose incomes are no more than the state's AFDC/TANF eligibility level. North Carolina requests a waiver of these requirements to the extent that family planning services provided to women and men who would not otherwise be eligible for Medicaid could be deemed to constitute erroneous payments or payments could be made for individuals who are no longer entitled to the support level to which they were entitled at the time of the initial application.
- 3** *Other Restrictions.* North Carolina requests that a referral to the Office of Child Support Enforcement (OCSE) not be required. A recipient should not be required to cooperate with OCSE during her/his eligibility for family planning waiver services only. (42 CFR 435.610(a)(2))

Applicants under this waiver will still be subject to third party liability limits. (42 CFR 435.610)

North Carolina requests that the Department of Health and Human Services (DHHS) grant any other waiver that DHHS deems necessary to implement the family planning waiver services for women and men who meet the eligibility requirements described in this waiver application.

REFERENCES

- Contraception Counts: State-by-State Information. *Issues In Brief*. The Alan Guttmacher Institute, 1998.
- Edens, N. "A Medicaid Waiver Proposal for North Carolina: - A Strategy to Reduce Unintended Pregnancy and Improve the Well-Being of Women, Children, and Families", Unpublished paper, p 18, December 1999.
- Forrest, JD and Frost, J. "The Family Planning Attitudes and Experiences of Low Income Women", *Family Planning Perspectives*, 36(6):246-277, November/December 1996.
- Forrest, JD and Samara, R. "Impact of Publicly Funded Contraceptive Services on Unintended Pregnancies and Implications for Medicaid Expenditures", *Family Planning Perspectives*, 28(5): 188-195, 1996.
- Glasgow, RE, Vogt, TM and Boles, SM. "Evaluating the Public Health Impact of Health Promotion Interventions: The RE-AIM Framework", *American Journal of Public Health*, 89: 1322-1327, 1999.
- Gold, RB and Sonfield, A. "Block Grants Are Key Sources of Support for Family Planning", *The Guttmacher Report on Public Policy*, 2(4):6-9, 1999.
- Institute of Medicine. *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families*, 1995.
- Jamieson, DJ and Buescher, PA. "The Effect of Family Planning Participation on Prenatal Care Use and Low Birth Weight", *Family Planning Perspectives*, 24(5):214-218, 1992.
- Koonin, LM, Strauss, LT, Chrisman, CE, Montalbano, MA, Bartlett, LA and Smith, JC. "Abortion Surveillance - United States, 1996", *Morbidity and Mortality Weekly Report*, 48(SS-4): 1-42, 1999.
- March of Dimes. "Perinatal Profiles: Statistics for Monitoring State Maternal and Infant Health", NC Edition, 1999.
- North Carolina State Center for Health Statistics. *Pregnancy Risk Assessment Monitoring System for North Carolina*, 1998.
- Trussel, James, et al., "Economic Value of Contraception: A Comparison of Fifteen Methods", *American Journal of Public Health*, 85(4):494-503, April 1995.
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ATTACHMENT I**Services Covered Under the Family Planning Waiver Project**

Women and men eligible for the family planning waiver project will be covered for a limited package of health services.

The following services will be covered:

- A. Office/Outpatient medical visits for family planning purposes which include:
 - 1) Complete new and annual physical examination;
 - 2) Brief visits for method follow-up (e.g. next Depo-Provera injection);
 - 3) Extended interim visits for follow-up on family planning related problems;
 - 4) Pelvic examination, including bimanual and speculum, and pap smears annually, unless clinical indication for more frequent examination exists;
 - 5) Breast examination;
 - 6) Testicular and prostate examinations, as indicated;
 - 7) Rectal examination, if indicated;
 - 8) Basic education regarding human sexuality and reproduction;
 - 9) Advice and counseling regarding all family planning methods, including natural family planning measures and sterilization procedures, the availability and effectiveness of methods, procedures involved in each, and untoward effects and potential complications of each method;
 - 10) Referral mechanism and documented referral for all patients demonstrating illness, disease, or pregnancy; and
 - 11) Follow-up for contraceptive-related complications.
 - B. Pregnancy test if indicated by physical examination or history, or both, when performed by either the medical practitioner or the laboratory.
 - C. The following laboratory tests:
 - 1) Hemoglobin or hematocrit, or both;
 - 2) Urinalysis for albumin sugar;
 - 3) Urine culture and sensitivity studies;
 - 4) Serologic tests for syphilis;
 - 5) Gonorrhea and chlamydia screening;
 - 6) Tests for Human Immunodeficiency Viruses (voluntary and confidential) and referral;
 - 7) Herpes culture;
 - 8) Smear wet mount and KOH with interpretation;
 - 9) Rubella titer for those without documentation of prior rubella immunization;
 - 10) Pap smear;
 - 11) Blood glucose;
 - 12) Glucose tolerance tests; and
 - 13) Other tests necessary in conjunction with the family planning visit/related to contraceptive method.
 - D. Colposcopies with or without biopsy as warranted.
 - E. Pharmaceutical supplies and devices to prevent conception through chemical, mechanical, or other methods, which are covered by the North Carolina Medical Assistance Program.
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- F. Tubal ligation or vasectomy when performed according to criteria in 42 CFR 441.20, and when the appropriate forms are properly completed and attached to the claim. Appropriate and necessary post-procedure follow-up visits and laboratory examinations will also be covered.
- G. Pharmaceuticals necessary in the treatment of diagnosed STDs (per 1998 CDC Guidelines for Treatment of Sexually Transmitted Diseases).
- H. Immunization for Hepatitis B if recipient falls into Medicaid covered risk group(s).

The following services will not be covered:

- A. Abortions.
- B. Hysterectomies.
- C. Mammograms
- D. Infertility services (other than Title X's Level 1 Infertility Services).
- E. Treatment for HIV/AIDS or cancer.
- F. Management or treatment of medical conditions/problems (**not** including STDs) discovered during screenings, caused by or following a family planning procedure (i.e. medical complications from family planning procedures) - e.g. UTIs, diabetes, hypertension, breast lumps, stroke, etc.
- G. Immunizations (other than Hepatitis B).
- H. TB testing and follow-up.
- I. Services not medically necessary or appropriate

Providers should make appropriate referrals to other sources of assistance with non-covered services (e.g. Health Departments for TB and immunization needs, the Cancer Control Program, Infectious Disease Clinics)

There will be no copayments for any services covered under this program.

Recipients will not be required to receive a referral from a primary care physician, enroll with Carolina ACCESS or an HMO (in counties with this requirement for Medicaid recipients).

ATTACHMENT II

Budget Information

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

	YEAR 1 01/01/01	PERCENT OF TOTAL RECIPS	AVE MONTHLY COST PER RECIP	ANNUAL RECIPIENT MONTHS 13,390	ESTIMATED FINANCIAL IMPACT YEAR 1
536101	HOSP INPT-GENERAL	41.13%			(26,531)
536102	HOSP INPT-SPECIALITY	0.00%			(2)
536105001	HOSP INPT-MTL, NSO < 21	0.01%			(5)
536115	PHYSICIAN	26.64%			(17,185)
536116	DENTAL	0.41%			(263)
536117	OPTICAL SUPPLIES	0.00%			(1)
536118	CHIROPRACTIC	0.02%			(14)
536119	OPTICAL	0.00%			(3)
536120	PODIATRY	0.00%			(2)
536121	HOSP OUTPT-GENERAL	6.60%			(4,255)
536123	CLINICS-MENTAL HEALTH-FSO	0.32%			(209)
536124	CLINICS-HEALTH DEPT	12.14%			(7,831)
536126	CLINICS-RURAL HEALTH	0.21%			(134)
536128	LAB AND X-RAY	1.64%			(1,056)
536129	HOME HEALTH	0.31%			(200)
536130	PRESCRIBED DRUGS	3.66%			(2,363)
536132	FAMILY PLAN-STERILIZATION	8.06%	\$866.75	1,079	935,594
536133	FAMILY PLAN-HOSP INPT	0.00%	\$0.00	0	0
536134	FAMILY PLAN-HOSP OUTPT	0.57%	\$585.19	76	44,530
536135	FAMILY PLAN-PHYSICIAN	12.94%	\$64.48	1,733	111,767
536136	FAMILY PLAN-HEALTH DEPT	21.64%	\$98.32	2,897	284,863
536137	FAMILY PLAN-FREE STANDING	0.02%	\$82.23	3	232
536138	HIV CASE MANAGEMENT	0.01%			(5)
536139	HEALTH CHECK-HEALTH DEPT	0.02%			(10)
536140	PART B BUY-IN NON CASH	0.01%			(4)
536142	AMBULANCE	0.13%			(82)
536144	PERSONAL CARE	0.01%			(5)
536146	HEALTH CHECK-RURAL HLTH CTR	0.00%			(0)
536147	HEALTH CHECK-OTHER PROV	0.00%			(2)
536148	FAMILY PLAN-RURAL HEALTH	0.46%	\$72.34	62	4,485
536149	FAMILY PLAN-DRUGS	55.42%	\$39.75	7,421	295,007
536154	HOSP OUTPT-EMERGENCY ROOM	3.07%			(1,982)
536156	HOSP INPT-GENERAL-XOVERS	0.01%			(8)
536158	HOSP OUTPT-GENERAL-XOVERS	0.01%			(5)
536162	CASE MANAGEMENT-FSO	0.00%			(2)
536165	DURABLE MED EQUIPMENT	0.14%			(88)
536170	HMO PREMIUMS	2.52%			(1,626)
536171	HOME INFUSION THERAPY	0.09%			(56)
536177	CLINICS-FQHC, CORE & AMBULAT	0.77%			(495)
536178	FAMILY PLAN-FQHC	0.88%	\$57.61	118	6,819
536181	HOSP INPT-INDIAN HEALTH	0.00%			(2)
536182	HOSP OUTPT-INDIAN HEALTH	0.04%			(26)
536187	AMBULATORY SURG CENTER	0.07%			(48)
	(FIRST YEAR NET IMPACT				1,618,797

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

	Year 2	PERCENT OF TOTAL RECIPS	AVE MONTHLY COST PER RECIP	ANNUAL MONTHLY RECIPIENTS 86,972	ESTIMATED FINANCIAL IMPACT
536101	HOSP INPT-GENERAL	41.13%			(601,564)
536102	HOSP INPT-SPECIALITY	0.00%			(35)
536105001	HOSP INPT-MTL, NSO < 21	0.01%			(108)
536115	PHYSICIAN	26.64%			(389,663)
536116	DENTAL	0.41%			(5,973)
536117	OPTICAL SUPPLIES	0.00%			(16)
536118	CHIROPRACTIC	0.02%			(327)
536119	OPTICAL	0.00%			(66)
536120	PODIATRY	0.00%			(43)
536121	HOSP OUTPT-GENERAL	6.60%			(96,488)
536123	CLINICS-MENTAL HEALTH-FSO	0.32%			(4,732)
536124	CLINICS-HEALTH DEPT	12.14%			(177,567)
536126	CLINICS-RURAL HEALTH	0.21%			(3,040)
536128	LAB AND X-RAY	1.64%			(23,939)
536129	HOME HEALTH	0.31%			(4,543)
536130	PRESCRIBED DRUGS	3.66%			(53,589)
536132	FAMILY PLAN-STERILIZATION	8.06%	\$908.35	1,079	980,503
536133	FAMILY PLAN-HOSP INPT	0.00%	\$0.00	0	0
536134	FAMILY PLAN-HOSP OUTPT	0.57%	\$617.37	76	46,979
536135	FAMILY PLAN-PHYSICIAN	12.94%	\$66.80	1,733	115,791
536136	FAMILY PLAN-HEALTH DEPT	21.64%	\$104.22	2,897	301,955
536137	FAMILY PLAN-FREE STANDING	0.02%	\$87.16	3	246
536138	HIV CASE MANAGEMENT	0.01%			(105)
536139	HEALTH CHECK-HEALTH DEPT	0.02%			(234)
536140	PART B BUY-IN NON CASH	0.01%			(96)
536142	AMBULANCE	0.13%			(1,851)
536144	PERSONAL CARE	0.01%			(111)
536146	HEALTH CHECK-RURAL HLTH CTR	0.00%			(1)
536147	HEALTH CHECK-OTHER PROV	0.00%			(40)
536148	FAMILY PLAN-RURAL HEALTH	0.46%	\$76.68	62	4,754
536149	FAMILY PLAN-DRUGS	55.42%	\$44.72	7,421	331,883
536154	HOSP OUTPT-EMERGENCY ROOM	3.07%			(44,936)
536156	HOSP INPT-GENERAL-XOVERS	0.01%			(185)
536158	HOSP OUTPT-GENERAL-XOVERS	0.01%			(121)
536162	CASE MANAGEMENT-FSO	0.00%			(42)
536165	DURABLE MED EQUIPMENT	0.14%			(1,990)
536170	HMO PREMIUMS	2.52%			(36,862)
536171	HOME INFUSION THERAPY	0.09%			(1,270)
536177	CLINICS-FQHC, CORE & AMBULATORY	0.77%			(11,234)
536178	FAMILY PLAN-FQHC	0.88%	\$61.06	118	7,228
536181	HOSP INPT-INDIAN HEALTH	0.00%			(44)
536182	HOSP OUTPT-INDIAN HEALTH	0.04%			(595)
536187	AMBULATORY SURG CENTER	0.07%			(1,084)
	SECOND YEAR NET IMPACT				326,846

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF **MEDICAL** ASSISTANCE
FINANCIAL OPERATIONS

	Year 3	PERCENT OF TOTAL RECIPS	AVE MONTHLY COST PER RECIP	ANNUAL MONTHLY RECIPIENTS 152,249	ESTIMATED FINANCIAL IMPACT
	Total				
536101	HOSP INPT-GENERAL	41.13%			(639,891)
536102	HOSP INPT-SPECIALITY	0.00%			(37)
536105001	HOSP INPT-MTL, NSO < 21	0.01%			(115)
536115	PHYSICIAN	26.64%			(414,489)
536116	DENTAL	0.41%			(6,354)
536117	OPTICAL SUPPLIES	0.00%			(17)
536118	CHIROPRACTIC	0.02%			(347)
536119	OPTICAL	0.00%			(70)
536120	PODIATRY	0.00%			(46)
536121	HOSP OUTPT-GENERAL	6.60%			(102,636)
536123	CLINICS-MENTAL HEALTH-FSO	0.32%			(5,033)
536124	CLINICS-HEALTH DEPT	12.14%			(188,880)
536126	CLINICS-RURAL HEALTH	0.21%			(3,234)
536128	LAB AND X-RAY	1.64%			(25,464)
536129	HOME HEALTH	0.31%			(4,833)
536130	PRESCRIBED DRUGS	3.66%			(57,003)
536132	FAMILY PLAN-STERILIZATION	8.06%	\$951.95	1,079	1,027,567
536133	FAMILY PLAN-HOSP INPT	0.00%	\$0.00	0	0
536134	FAMILY PLAN-HOSP OUTPT	0.57%	\$651.33	76	49,563
536135	FAMILY PLAN-PHYSICIAN	12.94%	\$69.21	1,733	119,959
536136	FAMILY PLAN-HEALTH DEPT	21.64%	\$110.47	2,897	320,072
536137	FAMILY PLAN-FREE STANDING	0.02%	\$92.39	3	260
536138	HIV CASE MANAGEMENT	0.01%			(112)
536139	HEALTH CHECK-HEALTH DEPT	0.02%			
536140	PART B BUY-IN NON CASH	0.01%			(102)
536142	AMBULANCE	0.13%			(1,969)
536144	PERSONAL CARE	0.01%			(118)
536146	HEALTH CHECK-RURAL HLTH CTR	0.00%			(1)
536147	HEALTH CHECK-OTHER PROV	0.00%			(43)
536148	FAMILY PLAN-RURAL HEALTH	0.46%	\$81.28	62	5,040
536149	FAMILY PLAN-DRUGS	55.42%	\$50.31	7,421	373,368
536154	HOSP OUTPT-EMERGENCY ROOM	3.07%			(47,799)
536156	HOSP INPT-GENERAL-XOVERS	0.01%			(197)
536158	HOSP OUTPT-GENERAL-XOVERS	0.01%			(128)
536162	CASE MANAGEMENT-FSO	0.00%			(45)
536165	DURABLE MED EQUIPMENT	0.14%			(2,117)
536170	HMO PREMIUMS	2.52%			(39,210)
536171	HOME INFUSION THERAPY	0.09%			(1,351)
536177	CLINICS-FQHC, CORE & AMBULATORY	0.77%			(11,950)
536178	FAMILY PLAN-FQHC	0.88%	\$64.73	118	7,662
536181	HOSP INPT-INDIAN HEALTH	0.00%			(46)
536182	HOSP OUTPT-INDIAN HEALTH	0.04%			(633)
536187	AMBULATORY SURG CENTER	0.07%			(1,153)
	THIRD YEAR NET IMPACT				347,821

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DMSION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

		PERCENT OF TOTAL RECIPS	AVE MONTHLY COST PER RECIP	ANNUAL MONTHLY RECIPIENTS 198,963	ESTIMATED FINANCIAL IMPACT
536101	HOSP INPT-GENERAL	41.13%			(688,356)
536102	HOSP INPT-SPECIALITY	0.00%			(40)
536105001	HOSP INPT-MTL, NSO < 21	0.01%			(124)
536115	PHYSICIAN	26.64%			(445,882)
536116	DENTAL	0.41%			(6,835)
536117	OPTICAL SUPPLIES	0.00%			(19)
536118	CHIROPRACTIC	0.02%			(374)
536119	OPTICAL	0.00%			(75)
536120	PODIATRY	0.00%			(49)
536121	HOSP OUTPT-GENERAL	6.60%			(110,409)
536123	CLINICS-MENTAL HEALTH-FSO	0.32%			(5,414)
536124	CLINICS-HEALTH DEPT	12.14%			(203,186)
536126	CLINICS-RURAL HEALTH	0.21%			(3,479)
536128	LAB AND X-RAY	1.64%			(27,393)
536129	HOME HEALTH	0.31%			(5,199)
536130	PRESCRIBED DRUGS	3.66%			(61,321)
536132	FAMILY PLAN-STERILIZATION	8.06%	\$997.65	1,079	1,076,890
536133	FAMILY PLAN-HOSP INPT	0.00%	\$0.00	0	0
536134	FAMILY PLAN-HOSP OUTPT	0.57%	\$687.15	76	52,289
536135	FAMILY PLAN-PHYSICIAN	12.94%	\$71.70	1,733	124,278
536136	FAMILY PLAN-HEALTH DEPT	21.64%	\$117.10	2,897	339,276
536137	FAMILY PLAN-FREE STANDING	0.02%	\$97.94	3	276
536138	HIV CASE MANAGEMENT	0.01%			(120)
536139	HEALTH CHECK-HEALTH DEPT	0.02%			(267)
536140	PART B BUY-IN NON CASH	0.01%			(110)
536142	AMBULANCE	0.13%			(2,118)
536144	PERSONAL CARE	0.01%			(127)
536146	HEALTH CHECK-RURAL HLTH CTR	0.00%			(1)
536147	HEALTH CHECK-OTHER PROV	0.00%			(46)
536148	FAMILY PLAN-RURAL HEALTH	0.46%	\$86.16	62	5,342
536149	FAMILY PLAN-DRUGS	55.42%	\$56.60	7,421	420,039
536154	HOSP OUTPT-EMERGENCY ROOM	3.07%			(51,419)
536156	HOSP INPT-GENERAL-XOVERS	0.01%			(212)
536158	HOSP OUTPT-GENERAL-XOVERS	0.01%			(138)
536162	CASE MANAGEMENT-FSO	0.00%			(48)
536165	DURABLE MED EQUIPMENT	0.14%			(2,277)
536170	HMO PREMIUMS	2.52%			(42,180)
536171	HOME INFUSION THERAPY	0.09%			(1,453)
536177	CLINICS-FQHC, CORE & AMBULAT	0.77%			(12,855)
536178	FAMILY PLAN-FQHC	0.88%	\$68.61	118	8,121
536181	HOSP INPT-INDIAN HEALTH	0.00%			(50)
536182	HOSP OUTPT-INDIAN HEALTH	0.04%			(681)
536187	AMBULATORY SURG CENTER	0.07%			(1,240)
	FOURTH YEAR NET IMPACT				353,016

		PERCENT OF TOTAL RECIPS	AVE MONTHLY COST PER RECIP	ANNUAL MONTHLY RECIPIENTS 225,150	ESTIMATED FINANCIAL IMPACT
536101	HOSP INPT-GENERAL	41.13%			(741,993)
536102	HOSP INPT-SPECIALITY	0.00%			(43)
536105001	HOSP INPT-MTL, NSO < 21	0.01%			(134)
536115	PHYSICIAN	26.64%			(480,625)
536116	DENTAL	0.41%			(7,368)
536117	OPTICAL SUPPLIES	0.00%			(20)
536118	CHIROPRACTIC	0.02%			(403)
536119	OPTICAL	0.00%			(81)
536120	PODIATRY	0.00%			(53)
536121	HOSP OUTPT-GENERAL	6.60%			(119,012)
536123	CLINICS-MENTAL HEALTH-FSO	0.32%			(5,836)
536124	CLINICS-HEALTH DEPT	12.14%			(219,018)
536126	CLINICS-RURAL HEALTH	0.21%			(3,750)
536128	LAB AND X-RAY	1.64%			(29,527)
536129	HOME HEALTH	0.31%			(5,604)
536130	PRESCRIBED DRUGS	3.66%			(66,099)
536132	FAMILY PLAN-STERILIZATION	8.06%	\$1,045.53	1,079	1,128,581
536133	FAMILY PLAN-HOSP INPT	0.00%	\$0.00	0	0
536134	FAMILY PLAN-HOSP OUTPT	0.57%	\$724.95	76	55,165
536135	FAMILY PLAN-PHYSICIAN	12.94%	\$74.28	1,733	128,752
536136	FAMILY PLAN-HEALTH DEPT	21.64%	\$124.13	2,897	359,633
536137	FAMILY PLAN-FREE STANDING	0.02%	\$103.81	3	293
536138	HIV CASE MANAGEMENT	0.01%			(129)
536139	HEALTH CHECK-HEALTH DEPT	0.02%			(288)
536140	PART B BUY-IN NON CASH	0.01%			(119)
536142	AMBULANCE	0.13%			(2,283)
536144	PERSONAL CARE	0.01%			(137)
536146	HEALTH CHECK-RURAL HLTH CTR	0.00%			(1)
536147	HEALTH CHECK-OTHER PROV	0.00%			(49)
536148	FAMILY PLAN-RURAL HEALTH	0.46%	\$91.33	62	5,663
536149	FAMILY PLAN-DRUGS	55.42%	\$63.68	7,421	472,544
536154	HOSP OUTPT-EMERGENCY ROOM	3.07%			(55,426)
536156	HOSP INPT-GENERAL-XOVERS	0.01%			(228)
536158	HOSP OUTPT-GENERAL-XOVERS	0.01%			(149)
536162	CASE MANAGEMENT-FSO	0.00%			(52)
536165	DURABLE MED EQUIPMENT	0.14%			(2,455)
536170	HMO PREMIUMS	2.52%			(45,466)
536171	HOME INFUSION THERAPY	0.09%			(1,566)
536177	CLINICS-FQHC, CORE & AMBULAT	0.77%			(13,857)
536178	FAMILY PLAN-FQHC	0.88%	\$72.73	118	8,609
536181	HOSP INPT-INDIAN HEALTH	0.00%			(54)
536182	HOSP OUTPT-INDIAN HEALTH	0.04%			(734)
536187	AMBULATORY SURG CENTER	0.07%			(1,337)
	FIFTH YEAR NET IMPACT				355,344

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

MEDICAID FINANCIAL PARTICIPATION RATES

ACCOUNT	CATEGORY OF SERVICE	SFY 2000-01 FEDERAL FP RATES	SFY 2000-01 COUNTY FP RATES	SFY 2001-02 FEDERAL FP RATES	SFY 2001-02 COUNTY FP RATES	SFY 2002-03 FEDERAL FP RATES	SFY 2002-03 COUNTY FP RATES	SFY 2003-04 FEDERAL FP RATES	SFY 2003-04 COUNTY FP RATES	SFY 2004-05 FEDERAL FP RATES	SFY 2004-05 COUNTY FP RATES
536101	HOSP INPT-GENERAL	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536102	HOSP INPT-SPECIALITY	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536105001	HOSP INPT-MTL NSO < 21	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536115	PHYSICIAN	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536116	DENTAL	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536117	OPTICAL SUPPLIES	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536118	CHIROPRACTIC	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536119	OPTICAL	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536120	PODIATRY	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536121	HOSP OUTPT-GENERAL	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536123	CLINICS-MENTAL HEALTH	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536124	CLINICS-HEALTH DEPT	0.6248	0.0213	0.6225	0.0250	0.6198	0.0280	0.6175	0.0305	0.6151	0.0335
536126	CLINICS-RURAL HEALTH	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536128	LAB AND X-RAY	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536129	LTC HOME HEALTH	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536130	PRESCRIBED DRUGS	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536132	FAMILY PLAN-STERILIZATION	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536134	FAMILY PLAN-HOSP OUTPT	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536135	FAMILY PLAN-PHYSICIAN	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536136	FAMILY PLAN-HEALTH DEPT	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536137	FAMILY PLAN-FREE STANDING	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536138	HIV CASE MANAGEMENT	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536139	HEALTH CHECK-HEALTH DEPT	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536140	PART B BUY-IN NON CASH	0.0000	0.1500	0.0000	0.1500	0.0000	0.1500	0.0000	0.1500	0.0000	0.1500
536142	AMBULANCE	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536144	LTC PERSONAL CARE	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536146	HEALTH CHECK-RURAL HLTH CTR	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536147	HEALTH CHECK-OTHER PROV	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536148	FAMILY PLAN-RURAL HLTH CTR	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536149	FAMILY PLAN-DRUGS	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536154	HOSP OUTPT-EMERGENCY ROOM	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536156	HOSP INPT-GENERAL-XOVERS	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536158	HOSP OUTPT-GENERAL-XOVERS	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536162	HOSP OUTPT-GENERAL-FSO	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000
536165	CASE MANAGEMENT-EQUIPMENT	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536170	HMO PREMIUMS	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536171	HOME INFUSION THERAPY	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536177	CLINICS-FQHC, CORE & AMBULAT	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536178	FAMILY PLANNING-FQHC	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577
536181	HOSP INPT-INDIAN HEALTH	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150	0.9000	0.0150
536182	HOSP OUTPT-INDIAN HEALTH	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000	1.0000	0.0000
536187	AMBULATORY SURG CENTER	0.6248	0.0563	0.6225	0.0566	0.6198	0.0570	0.6175	0.0574	0.6151	0.0577

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE
FINANCIAL OPERATIONS

		ACCOUNT	PAID	RECIPS	PERCENT RECIPIENTS OF TOTAL	AVE COST PER RECIP PER MONTH	AVE COST ADJUSTED TO SFY 2001
AFDC OVER 21							
024	FAMILY PLAN-STERILIZATION	536132	1,876,744	383	8.06%	\$816.69	\$866.75
010	FAMILY PLAN-HOSP INPT	536133	0	0	0.00%	\$0.00	\$0.00
011	FAMILY PLAN-HOSP OUTPT	536134	89,325	27	0.57%	\$551.39	\$585.19
012	FAMILY PLAN-PHYSICIAN	536135	224,198	615	12.94%	\$60.76	\$64.48
038	FAMILY PLAN-HEALTH DEPT	536136	571,417	1,028	21.64%	\$92.64	\$98.32
008	FAMILY PLAN-FREE STANDING	536137	465	1	0.02%	\$77.48	\$82.23
037	FAMILY PLAN-RURAL HEALTH	536148	8,997	22	0.46%	\$68.16	\$72.34
031	FAMILY PLAN-DRUGS	536149	591,766	2,633	55.42%	\$37.46	\$39.75
066	FAMILY PLAN-FQHC	536178	13,678	42	0.88%	\$54.28	\$57.61
				4,751			

Medicaid Waiver
Adult (20-44) Matrix
Year 1 of 5

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 1	January	February	March	April	May	June	July	August	September	October	November
January	68	64.9	68	61.4	597	579	562	544	527	509	492
February	0	66.7	66	632	614	597	579	562	544	527	492
March	0	0	66.7	649	632	614	597	579	562	544	527
April	0	0	0	667	649	632	614	597	579	562	544
May	0	0	0	0	667	649	632	614	597	579	562
June	0	0	0	0	0	667	649	632	614	597	579
July	0	0	0	0	0	0	667	649	632	614	597
August	0	0	0	0	0	0	0	667	649	632	614
September	0	0	0	0	0	0	0	0	667	649	632
October	0	0	0	0	0	0	0	0	0	667	643
November	0	0	0	0	0	0	0	0	0	0	667
December	0	0	0	0	0	0	0	0	0	0	667
Year 2	January	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0
Year 3	January	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0
Year 1	January	456	439	421	404	386	369	351	334	299	281
February	474	456	439	421	404	386	369	351	334	316	299
March	492	474	456	439	421	404	386	369	351	334	316
April	509	492	474	456	439	421	404	386	369	351	334
May	527	509	492	474	456	439	421	404	386	369	351
June	544	527	509	492	474	456	439	421	404	386	369
July	562	544	527	509	492	474	456	439	421	404	386
August	579	562	544	527	509	492	474	456	439	421	404
September	597	579	562	544	527	509	492	474	456	439	421
October	614	597	579	562	544	527	509	492	474	456	439
November	632	614	597	579	562	544	527	509	492	474	456
December	643	632	614	597	579	562	544	527	509	492	474
Year 2	January	833	811	789	767	745	723	702	680	636	614
February	0	833	811	789	767	745	723	702	680	636	614
March	0	0	833	811	789	767	745	723	702	636	614
April	0	0	0	833	811	789	767	745	723	680	636
May	0	0	0	0	833	811	789	767	745	723	680
June	0	0	0	0	0	833	811	789	767	745	723
July	0	0	0	0	0	0	833	811	789	767	745
August	0	0	0	0	0	0	0	833	811	789	767
September	0	0	0	0	0	0	0	0	833	811	789
October	0	0	0	0	0	0	0	0	0	833	811
November	0	0	0	0	0	0	0	0	0	0	833
December	0	0	0	0	0	0	0	0	0	0	833
Year 3	January	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0

Medicaid Waiver
Adult (20-44) Matrix
Year 2 of 5

Additional Medicaid Eligibles Served by Month, Less Discontinued Users

Year 1	January	February	March	April	May	June	July	August	September	October	November	December
January	456	439	421	404	386	369	351	334	316	299	281	264
February	474	456	439	421	404	386	369	351	334	316	299	281
March	492	474	456	439	421	404	386	369	351	334	316	299
April	509	492	474	456	439	421	404	386	369	351	334	316
May	527	509	492	474	456	439	421	404	386	369	351	334
June	544	527	509	492	474	456	439	421	404	386	369	351
July	562	544	527	509	492	474	456	439	421	404	386	369
August	579	562	544	527	509	492	474	456	439	421	404	386
September	597	579	562	544	527	509	492	474	456	439	421	404
October	614	597	579	562	544	527	509	492	474	456	439	421
November	632	614	597	579	562	544	527	509	492	474	456	439
December	643	632	614	597	579	562	544	527	509	492	474	456
Year 2	January	833	811	789	767	745	723	702	680	636	614	592
February	0	833	811	789	767	745	723	702	680	636	614	592
March	0	0	833	811	789	767	745	723	702	636	614	592
April	0	0	0	833	811	789	767	745	723	680	636	614
May	0	0	0	0	833	811	789	767	745	723	680	636
June	0	0	0	0	0	833	811	789	767	745	723	680
July	0	0	0	0	0	0	833	811	789	767	745	723
August	0	0	0	0	0	0	0	833	811	789	767	745
September	0	0	0	0	0	0	0	0	833	811	789	767
October	0	0	0	0	0	0	0	0	0	833	811	789
November	0	0	0	0	0	0	0	0	0	0	833	811
December	0	0	0	0	0	0	0	0	0	0	0	833
Year 3	January	0	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0	0

Year 4												Year 5											
January	0	0	0	0	0	0	0	0	0	0	0	0	January	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0	0	February	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0	0	March	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0	0	April	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0	0	May	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0	0	June	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0	0	July	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0	0	August	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0	0	September	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0	0	October	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0	0	November	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0	0	December	0	0	0	0	0	0	0	0	0	0

Total	667	1316	1948	2562	315	3,78	4300	4844	5271	588	6366	6840 Total	7462	8069	8647	9204	9738	10251	1074	11212	11659	12085	12488	12870												
Total Annual Recipient Months																																				
Estimated Pregnancies Averted by Year (Cutright and Jaffe, 1977)																																				
												46,991											86,972													
												39											440													
																								124,427												
																								840												

Single Year Cost Savings (Source: US Office of Population Affairs, 1995)

Average Cost Per Averted Pregnancy (inflated Annually at 6.13%)

Inflation Rate

Annual Average Number of Recipients

Annual Percent Averted Pregnancies of Annual Recipients

(\$64,500)

(\$127,065) Single Year Cost Savings (Source: US Office of Population Affairs, 1 (\$1,462,492)

-\$3,225.00 Average Cost Per Averted Pregnancy (inflated Annually at 6.13%)

Inflation Rate

3,916 Annual Average Number of Recipients

1.01% Annual Percent Averted Pregnancies of Annual Recipients

(\$2,876,431)

-\$3,42,69

613%

10369

810%

Calculation of	667.00
Annual	833.00
Increase in	917.00
Recipients	1,009.47
In years 4&5	1,111.27

Medicaid Waiver
Adult (20-44) Matrix
Year 3 of 5

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 1	January	February	March	April	May	June	July	August	September	October	November
January	246	228	211	193	176	158	141	123	106	88	71
February	264	246	228	211	193	176	158	141	123	106	88
March	281	264	246	228	211	193	176	158	141	123	106
April	164	281	264	246	228	211	193	176	158	141	123
May	188	164	281	264	246	228	211	193	176	158	141
June	212	188	164	281	264	246	228	211	193	176	158
July	236	212	188	164	281	264	246	228	211	193	176
August	260	236	212	188	164	281	264	246	228	211	193
September	284	260	236	212	188	164	281	264	246	228	211
October	308	284	260	236	212	188	164	281	264	228	211
November	332	308	284	260	236	212	188	164	281	264	228
December	356	332	308	284	260	236	212	188	164	281	264

Medicaid Waiver
Adult (20-44) Matrix
Year 4 of 5

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 1	January	February	March	April	May	June	July	August	September	October	November
January	246	228	211	193	176	158	141	123	106	88	71
February	264	246	228	211	193	176	158	141	123	106	88
March	281	264	246	228	211	193	176	158	141	123	106
April	164	281	264	246	228	211	193	176	158	141	123
May	188	164	281	264	246	228	211	193	176	158	141
June	212	188	164	281	264	246	228	211	193	176	158
July	236	212	188	164	281	264	246	228	211	193	176
August	260	236	212	188	164	281	264	246	228	211	193
September	284	260	236	212	188	164	281	264	246	228	211
October	308	284	260	236	212	188	164	281	264	228	211
November	332	308	284	260	236	212	188	164	281	264	228
December	356	332	308	284	260	236	212	188	164	281	264

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 2	January	February	March	April	May	June	July	August	September	October	November
January	570	548	526	504	482	461	439	417	395	373	351
February	592	570	548	526	504	482	461	439	417	395	373
March	614	592	570	548	526	504	482	461	439	417	395
April	636	614	592	570	548	526	504	482	461	439	417
May	658	636	614	592	570	548	526	504	482	461	439
June	680	658	636	614	592	570	548	526	504	482	461
July	702	680	658	636	614	592	570	548	526	504	482
August	723	702	680	658	636	614	592	570	548	526	504
September	745	723	702	680	658	636	614	592	570	548	526
October	767	745	723	702	680	658	636	614	592	570	548
November	789	767	745	723	702	680	658	636	614	592	570
December	811	789	767	745	723	702	680	658	636	614	592

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 3	January	February	March	April	May	June	July	August	September	October	November
January	917	893	869	845	821	796	772	748	724	700	676
February	0	917	893	869	845	821	796	772	748	724	700
March	0	0	917	893	869	845	821	796	772	748	724
April	0	0	0	917	893	869	845	821	796	772	748
May	0	0	0	0	917	893	869	845	821	796	772
June	0	0	0	0	0	917	893	869	845	821	796
July	0	0	0	0	0	0	917	893	869	845	821
August	0	0	0	0	0	0	0	917	893	869	845
September	0	0	0	0	0	0	0	0	917	893	869
October	0	0	0	0	0	0	0	0	0	917	893
November	0	0	0	0	0	0	0	0	0	0	917
December	0	0	0	0	0	0	0	0	0	0	0

Additional Medicaid Eligibles Served by Month, Less Discontinued Users											
Year 4	January	February	March	April	May	June	July	August	September	October	November
January	628	603	579	555	531	507	483	459	435	411	386
February	652	628	603	579	555	531	507	483	459	435	411
March	676	652	628	603	579	555	531	507	483	459	435
April	700	676	652	628	603	579	555	531	507	483	459
May	724	700	676	652	628	603	579	555	531	507	483
June	748	724	700	676	652	628	603	579	555	531	507
July	772	748	724	700	676	652	628	603	579	555	531
August	796	772	748	724	700	676	652	628	603	579	555
September	821	796	772	748	724	700	676	652	628	603	579
October	845	821	796	772	748	724	700	676	652	628	603
November	869	845	821	796	772	748	724	700	676	652	628
December	893	869	845	821	796	772	748	724	700	676	652

Year 4											
January	0	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0
Year 5											
January	0	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0
December	0	0	0	0	0	0	0	0	0	0	0

Total	12335	12837	13322	13789	14239	14671	15085	15481	15571	15932	16276	16602	Total	16848	170	18357	3588
Total Annual Recipient Months																	
Estimated Pregnancies Averted by Year (Culright and Jaffe, 1977)																	
Single Year Cost Savings (Source: US Office of Population Affairs, 1995)																	
Average Cost Per Averted Pregnancy (Initiated Annually at 6.13%)																	
Initiation Rate																	
Annual Average Number of Recipients																	
Annual Percent Averted Pregnancies of Annual Recipients																	

152,249
441

176,140
42

198,963
447

213,693
851

(\$154,309) Single Year Cost Savings (Source: US Office of Population Affairs, 1 (\$1,673,496)
-\$3,632.50 Average Cost Per Averted Pregnancy (Initiated Annually at 6.13%)
6.13% Initiation Rate
14,678 Annual Average Number of Recipients
0.29% Annual Percent Averted Pregnancies of Annual Recipients

(\$3,278,994)
-\$3,855.18
6.13%
17,808
4.78%

Medicaid Waiver Adult (20-44) Matrix Year 5 of 5												
Additional Medicaid Eligibles Served by Month, Less Discontinued Users												
Year 1	January	February	March	April	May	June	July	August	Sept	October	November	December
January	0	0	0	0	0	0	0	0	0	0	0	0
February	0	0	0	0	0	0	0	0	0	0	0	0
March	0	0	0	0	0	0	0	0	0	0	0	0
April	0	0	0	0	0	0	0	0	0	0	0	0
May	0	0	0	0	0	0	0	0	0	0	0	0
June	0	0	0	0	0	0	0	0	0	0	0	0
July	0	0	0	0	0	0	0	0	0	0	0	0
August	0	0	0	0	0	0	0	0	0	0	0	0
September	0	0	0	0	0	0	0	0	0	0	0	0
October	0	0	0	0	0	0	0	0	0	0	0	0
November	0	0	0	0	0	0	0	0	0	0	0	0
December	18	0	0	0	0	0	0	0	0	0	0	0
Year 2												
January	44	22	0	0	0	0	0	0	0	0	0	0
February	66	44	22	0	0	0	0	0	0	0	0	0
March	88	66	44	22	0	0	0	0	0	0	0	0
April	110	88	66	44	22	0	0	0	0	0	0	0
May	132	110	88	66	44	22	0	0	0	0	0	0
June	154	132	110	88	66	44	22	0	0	0	0	0
July	176	154	132	110	88	66	44	22	0	0	0	0
August	198	176	154	132	110	88	66	44	22	0	0	0
September	220	198	176	154	132	110	88	66	44	22	0	0
October	241	220	198	176	154	132	110	88	66	44	22	0
November	263	241	220	198	176	154	132	110	88	66	44	22
December	285	263	241	220	198	176	154	132	110	88	66	44
Year 3												
January	338	314	290	266	242	218	193	169	145	121	97	73
February	362	338	314	290	266	242	218	193	169	145	121	97
March	386	362	338	314	290	266	242	218	193	169	145	121
April	411	386	362	338	314	290	266	242	218	193	169	145
May	435	411	386	362	338	314	290	266	242	218	193	169
June	459	435	411	386	362	338	314	290	266	242	218	193
July	483	459	435	411	386	362	338	314	290	266	242	218
August	507	483	459	435	411	386	362	338	314	290	266	242
September	531	507	483	459	435	411	386	362	338	314	290	266
October	555	531	507	483	459	435	411	386	362	338	314	290
November	579	555	531	507	483	459	435	411	386	362	338	314
December	603	579	555	531	507	483	459	435	411	386	362	338

